



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

CAMDEN FIRE INSURANCE ASSOC

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-98-B003-01

MFDR Date Received

APRIL 20, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$4,605.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 1997 to June 13, 1997	Outpatient Hospital Services	\$4,605.41	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following payment exception codes:
 - M – Reduced to fair and reasonable
 - R – Unrelated to compensable injury
 - Included in another billed procedure

Findings

1. According to the explanation of benefits, the service described as *R272 Sterile Supply*, in the amount of \$18.55 was denied for payment with reason code “R – UNRELATED TO COMPENSABLE INJURY.” The division hereby notifies the requestor that the unresolved issues of compensability require resolution pursuant to a Benefit Review Conference described in 28 Texas Administrative Code Chapter 141; therefore, the services denied under “R” are not reviewed as part of this medical fee dispute decision. The remaining services are therefore reviewed.
2. The remaining disputed services relate to an outpatient hospital admission. These services were not identified in an established fee guideline during the disputed dates of service; therefore, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, sec. 8.21(b) until such period that specific fee guidelines are established by the commission.”
3. The former Texas Workers’ Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that “Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle.”
4. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include “a summary of the requesting party's position regarding the dispute.” Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
5. Review of the submitted documentation finds that:
 - The requestor did not submit a position statement for consideration in this dispute.
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
 - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		04/02/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.